MDHS Redesign Adult Mental Health Workgroup Minutes

Meeting #2
September 6, 2011, 10:00 am to 3:15 pm
Johnston Public Library
Johnston, IA

MINUTES

Attendance

Workgroup Members: Deb Albrecht, Christopher Atchison, Lynne Baltzer, Jerry Bartruff, Teresa Bomhoff, Gilbert Cerveny, Becky Cleveland, Dr. Bhasker Dave, Chris Hoffman, Chuck Palmer, Patrick Schmitz, Kathy Stone

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; and Joel Fry, State Representative, House District 95 (Clarke County)

Facilitator: Kevin Martone, Technical Assistance Collaborative (TAC)

DHS Staff: Pam Alger, Theresa Armstrong, Jeanie Kerber, Laura Larkin, Julie Lovelady

Other Attendees:

Marilyn Austin	Iowa County CPC
Jennifer Bauer	CANDEO
Kris Bell	Senate Democratic Caucus Staff
Linda Brundies	Iowa Ombudsman
Scott Caldwell	Lutheran Services of Iowa
Melissa Conley	Chatham Oaks, Iowa City
Vivian Davis	Chatham Oaks, Iowa City
Michelle De La Riva	Richmond Center/Community and Family Resources
Deb Dixon	Iowa Dept. of Inspection and Appeals
Sara Eide	Mercy Health Network
Michelle Fiegl	The Peer Connection
Kent Hartwig	Easter Seals
Jennifer Herrington	Waubonsie Mental Health Center
Marijke Hodgson	NAMI
Malinda Lamb	6th Judicial District Dept. of Correctional Services

Todd Lange	Iowa Office of Consumer Affairs
Adele Lenane	Hillcrest Wellness Center
Janet Lindseth	
Barbara Murphy	ABCM Corporation
Liz O'Hara	Center for Disabilities and Development (CDD)
Brice Oakley	Iowa Alliance of CMHCs
Kelley Pennington	Magellan Health
Jessica Perry	Hillcrest Family Services/Peer Support Training Academy
J. Pindt	Chatham Oaks, Iowa City
Lorri Regan	Hillcrest Wellness Center
Angie Doyle Scar	Iowa Department of Public Health
Nicole Schultz	Iowa Pharmacy Association
Chelsea Schvog	Iowa Pharmacy Association
Deb Eckerman Slack	Iowa State Association of Counties/County Case Management
Julie Smith	Iowa Health System
Kim Scorza	Seasons Center
Bob Thacker	Northeast Iowa Behavioral Health
Deanna Triplett	Iowa Behavioral Health Association
Karen Walters-Crammond	Polk County Health Services
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

AGENDA

Agenda

- Re-cap for Meeting One: Review and Overlap with other Workgroups and comments on Minutes
- Eligibility Review and Discussion of Proposed Criteria
- Brief Presentation
    - National Trends influencing Services
    - Outcomes
    - Frameworks for Core Services with Examples
    - Magellan Services for Medicaid Recipients
    - Crisis and Sub-acute Services
    - Administration of Core Services in a Regional Framework
    - Co-occurring Disorders and Dual Diagnosis Considerations
- Development of Core Service Domains for Iowa
- Development of Iowa Core Services
    - Acute and Sub-Acute Care
    - Targeted Case Management
    - Other

MEETING SUMMARY

Introductions and Welcome-Chuck Palmer
Chuck asked for workgroup members with clinical experience as well as consumers to participate in a subgroup to review the standardized assessment process and help develop recommendations. This group will meet by phone.

Discussion on Eligibility Criteria-Kevin Martone
Kevin identified the following criteria from the previous meeting and presented a draft format to the group. Stated that the group seemed to be at consensus on a broader definition of eligibility**.**

Draft Eligibility Criteria

- Age-18 and older.
- Resident of state of Iowa.
- Financial-Range of 133 - 200% of Federal Poverty Level.
- Diagnosis-diagnosable mental illness, more consistent with the current Serious Mental Illness (SMI) definition than Chronic Mental Illness.
- Level of functioning-the group will consider this further after the small workgroup meets.

Workgroup Comments/Discussion Of The Eligibility Criteria

- In order to promote an integrated system and consistency, can it be the same eligibility for MH and SA?
- It is consistent with the criteria for IDPH Block Grant funded substance abuse services. These criteria could change to be more consistent with Mental Health.
- Mental Health and Substance Abuse service eligibility should be separate as the criteria and assessments are different.
- If the system is going to be COD capable, agencies could use assessment instruments from both systems.
- The systems should be integrated, as the clients overlap, their needs cross over, and it is better for patients to be served closer to their homes.
- Should an initial assessment be done first, then LOCUS or further assessment if needed?
- Crisis usually drives what happens first, but could do LOCUS as part of assessment.
- ASAM criteria is like a full assessment. Medicaid has SBIRT (Screening, Brief Intervention, Referral to Treatment) and other brief screening tools to determine if substance abuse is an issue.
- LOCUS or a functional assessment is part of the full assessment, just as the ASAM is.
- Clarification was requested on the purpose of the functional assessment. It was restated that it is to provide standardization of assessment but was not to override or replace clinical judgment.

- A question was asked about what the group is trying to draft. A functional assessment is useful, but should follow an initial assessment. For first line eligibility, do we need a broader tool?
- Chuck Palmer responded that the small group will review tools, how they work, and then make recommendations to the group. It is important to bring the Mental Health and Substance Abuse sides together. Chuck asked group members to think about how far to integrate the systems, as there is crossover among clients and providers.
- Kathy Stone responded that the details of how DHS and IDPH would work together was laid out in a statement several years ago and reviewed the content of that agreement regarding working together on co-occurring capability.

Further Comments From the Group Regarding Financial Eligibility

- If we are to develop a system focused on individuals' needs, it's difficult for individuals to deal with two systems and two providers, two health plans. Clients should not have to worry about which funding source is providing their services.
- Discussed proposed sliding scale for those under 200%..
- The exclusion of V codes was explained by Patrick Schmitz, and these are usually family or relational issues, not clinical diagnoses, and often excluded as covered services.
- What kind of rules, law etc. would be affected if there is further alignment between Substance Abuse and Mental Health? The group needs to be aware of changes to the bigger system as a result of these recommendations.
- Kathy Stone replied that she doesn't see need for rule or law changes currently but will track on them as the workgroup progresses.
- The difference between 150% and 200% of federal poverty level (FPL) is significant for clients. For an agency that serves both mental health and substance abuse, this would increase consistency. Urged not to bring substance abuse eligibility level down to 150% regardless of where the mental health level ends up.
- Chuck Palmer responded that there may need to be a review of the cost impact to the state if there is an increase to 200% FPL for eligibility for mental health services.
- There are also issues of individuals who go on Medicare and not receiving the services they previously did. Medicare supplements don't always cover beyond basic mental health services**.**
- Chuck Palmer: regarding services to seniors, DHS will ask an expert from the University of Iowa to address co-occurring aging and mental health issues. Chuck also said the redesign will be a four to five year process.
- Question was asked regarding the source of the funds the group is determining eligibility for.
- Chuck Palmer responded that funding streams will be Medicaid and non-Medicaid funds. There will need to be further definition of "resident." This will be addressed in the regional workgroup.

- Kevin Martone further added: It is standardized eligibility for all individuals including Medicaid and non-Medicaid. He also stated that the group will need to crosswalk eligibility requirements with other workgroups' criteria.

Core Services and Outcomes

Kevin Martone reviewed national work that has been done to identify core services. He reviewed the New Freedom Commission report and the Olmstead decision and discussed that states are trying to reshape their systems to be evidence based, but the mental health system has not kept up with evidence based practices. It is hard to change these systems for a variety of reasons including economic issues. It is difficult to develop and prioritize new services, while dealing with existing (legacy) systems. Other states are trying to take EBPs to scale. This is difficult in Iowa with its larger rural areas.

States are also grappling with how to standardize the service system. Accountability at the state and federal levels is driving need for more standardized accountability and assessment measures. This helps get the resources to where they are needed the most. In New Jersey, the state was able to look at data statewide to in order to improve decision making.

Regarding core services, the federal government is trying to define this through the SAMHSA Good and Modern Behavioral Health system document, which was shared at the last meeting.

Kevin reviewed page 11 of the Good and Modern document, which is a chart of services that should be available in a good and modern system.

Kevin discussed the need for acute care services and the need for a system that can respond at different stages/intercepts of a crisis, as opposed to response that is limited to emergency rooms, law enforcement or courts. The goal is to stabilize but prevention of further escalation or involvement with the system is also part of it**.** A good acute care system prevents and diverts people away from more intensive services.

Kevin presented the NAMI service array document.

Kevin asked the group to engage in a brainstorming session to Identify outcomes that the group wants from their system. He divided the outcomes into two sections: system level and individual. He also asked the group to consider if the core services identified are consistent with the outcomes desired from the system.

System Level Of Outcomes

- Engagement and access to services and the right services immediately and ongoing.
- Seamless transitions.
- Statewide quality and equitable.
- Attractive system that employs proper workforce to support the system.
- Crisis intervention at every level of the state. Intervene to avert hospitalization and provide follow up. Also provide coordination with law enforcement.

- Reduction in jail and corrections for MH individuals and reduction in recidivism rate.
- Improve primary health outcomes.
- Numbers of people served and dollars spent-acute vs. non-acute services.
- Need more array of services between home and hospital.
- Standardized data system and data tools so we are all providing and reporting the same thing.

Individual Level Outcomes

- Individuals will be independent.
- Maintaining community tenure, employment, being sober, residing in residence of choice, and have choice in services.
- Having options in providers-outpatient options, array of services for individual/ family choice.
- Reduction in hospitalization days.

Brainstorming on the high-level service domains needed in the system?

Discussion started with Acute Care. Kevin asked the group to list of types of services needed. These will be for the state/regional system. Providers will be determined later. Chuck commented that funding would flow to regional management structure. The region has to develop a provider system that provides the core services across the region. The core services will be available statewide.

Workgroup Comments

- Core services should be bigger than just what the CMHC provides. What level of services are we talking about? Also need to include primary care and correctional system for collaboration. Kevin suggested that the discussion be kept at a higher level. Correctional issues may be dealt with in acute care domain. Crisis services include law enforcement.
- It is most challenging when a person is in imminent danger to self or other. The system must have clinically managed 24-hour services.
- Recovery oriented services.
- Medical home model-would encourage alignment with other systems.
- It was suggested ordering the array from least to most.
- Chuck Palmer reiterated that the group can create an ideal system first**,** and then work on how to pay for it. Determination of eligibility and levels of access are all part of the long term process of change.
- Teresa Bomhoff passed out a handout to the group. She made a matrix/chart of the Good and Modern service chart, the NAMI service array and supports**,** core services for CMHCs from SF 525, DOJ cases, and Acute Care Task Force recommendations.
- Observations on this are that SF 525 requires consultation where the others don't.
- Only two models discuss primary care/behavioral health integration.
- Recovery supports covered in 3 of 5; jail diversion in 2 of 5.

- It helped to see the commonalities among the models.
- Rep. Schulte commented that 230A revisions were about what CMHC's were providing or what they should provide as part of new CMHC standards. Focused on what they do now, not what they might do in new system. It was not written to be consistent with redesign legislation.

Services For An Acute Care System

- MHI
- Hospitalization
- Crisis stabilization
- 24-hour crisis call lines
- 24-hour face-to-face crisis
- Short term respite outside of hospital –subacute level of care
- Mobile crisis teams-
    - Kevin discussed different models of mobile crisis. It is not always based with or initiated by law enforcement. Also commented that when the system is too focused on acute care, even with mobile crisis, people are more likely to end up in hospital. It is important to have off site diversionary programs to provide assessment and then decide if they need hospital level of care. Keeping the client out of the ER also mitigates federal EMTALA requirements that apply when the individual is in the ER. Some estimate that that 30% of those in the ER didn't need to be there.

Workgroup Comments

- Iowa has found that many people served in inpatient care are only in the hospital for a day. Implies that possibly they didn't need that level of care.
- Rural after hours doctors don't have the capacity to deal with mental health or don't have expertise so send them to the hospital instead.
- Kevin suggested that there could be psychiatric emergency screening in the emergency room or some type of satellite diversionary center that houses a crisis line or services.
- Could integrate substance abuse detox beds into short-term mental health crisis stabilization. Current crisis lines are in existence.
- Discussed difference between hot line versus warm line. Warm lines are peer staffed, more accessible for consumers.
- Hospitals that do not provide inpatient psychiatric care can provide 23-hour beds, but need to get paid even if there is no psychiatrist on staff.
- What does diversion mean? We need a consistent approach /strategy for diversion. How does it become a system strategy? How do we make it systemic, instead of an individual event?
- Once people know about options they will divert from higher end. They access higher end for lack of knowledge or access.
- Kevin commented that there should be a balance between the goal of serving in the least restrictive setting and the public safety net function. The mental health system has to provide both services. Kevin also stated that the mobile crisis system in New Jersey was underfunded**,** so more money was put in. An

unintended consequence was that more people were committed because there was more identification but not a commensurate increase in community services available.

- There is no coordinated way to get statewide acute care services. It is mostly about money and staff time, not about client needs.
- Diversion has been an episodic response; diversion needs to be the goal.
- Corrections have been trying to work this way when they look at individual cases, but a systemic way may be mental health courts or diversion at other intercepts.
- Primary care Mental Health/Substance Abuse screenings are also diversion methods.
- Screening, Brief Intervention Referral to Treatment (SBIRT) can save money by early intervention.
- Law enforcement has a sequential intercept model that could be applied for mental health**.**
- In acute care, should jail diversion be included? It is a broad category**,** but there are specific interventions such as CIT, that is an EBP**.**
- Bexar Co, Texas has a strong jail diversion program that includes short-term residential beds, detoxification, and crisis stabilization.
- Difference in Texas was it was funded by new money, not current funding. They did not have to give up something to get the new service.
- There is a concern about different hotlines and crisis response systems through mental health centers. They offer different answers and types of response, but a caller may frequently be told to call 911 or go to an emergency room. Each CMHC is different in their emergency response**.**
- This is why we need regional/statewide standards for crisis response**.**
- What would it take for after hours on call service to be available statewide?
- How does Magellan fit into it? What is their crisis response capacity?
- Suggestion to have a statewide crisis response line then funnel to local providers, similar to 1-800 bets off.

<u>Group Identified These Treatment Services</u>

- Outpatient services-individual, group, family
- Medication management services
- Psychiatrist and ARNP services
- Partial hospitalization
- Community support services
    - Worker is assigned to client who has SMI to help client stay in community, get services, help with meds, etc. It is different from TCM; it is direct support.
- Supported community living
- ACT teams

<u>Discussion/Comments</u>

- Definition of Case management was moved to the parking lot.
- Residential and sub acute-where do they fit in the service array?
- There is not much subacute care available-most is hospital based.

- Cherokee has a subacute program, which is privately operated but based on the grounds of the MHI.
- Group discussion on RCF licensure and whether the larger ones qualify as an Institute for Mental Disease (IMD).
- There is no program in place to move people from group homes to apartments.
- Some group homes are substandard.
- Department of Inspections and Appeals provides licensure and oversight but group unclear about what that means exactly.
- Perception is that RCF's are more for clients with an ID diagnosis; however, some clients with mental illness are served in them. It appears that they try to segregate the intellectual diagnosis and mental illness populations.
- Housing options for the ID /DD and MI populations are not equivalent.

Kevin's Comments

- Housing is a critical issue to a person in recovery. Many states are grappling with this. Large institutions are a dying breed, and group homes are greater than five people. Evidence says ACT teams and supported housing are more effective.
- Research doesn't support step down levels such as hospital to group home to community.
- Housing availability becomes an issue. Community buy-in and qualified staff are needed. Integration easier when done individually (scatter-site) as opposed to congregate housing.
- Discussed costs of supported housing versus group home setting. An estimate is $15,000 per year for supported housing versus $30,000+ for a group home. Research says that 24 hour structured settings do not tend to provide the positive outcomes that other models do.
- Also have to consider people who have been in the group homes for a long time – these people could possibly move to more independent settings The program may continue to operate but those with higher needs get the opportunity to move in.New money is focused on community options so people can move into these. Explore opportunities with the Iowa Housing Finance Agency.
- Have to consider residential basis of the current system when developing the new system.

Workgroup Comments

- Is there something in between 24-hour care and independent living? Some people need assisted living type services such as community meals, social interaction, safety net services, but also autonomy.
- Comment from Kevin: In an RCF, a person may be discharged for noncompliance with a rule. If they are in their own home and make the same choice, it doesn't mean they have to leave. This helps the individual maintain permanency and stability. Better outcomes.
- Assisted living could be more centered on what the individual wants.
- The federal housing agency has built congregate housing and assisted living for seniors but hasn't been targeted toward those with mental illness.

- Community Support Teams-Community Support Services could be part of this, also should be part of a treatment team. Similar to ACT but maybe not as intensive. Flexible supports tailored to people's needs.
- Case Management was added to the treatment domain.
- Recreational, personal care, homemaker, and transportation services were suggested and these will be added to the suggested supportive services domain.
- Questions about differences between Supported Community Living **(**SCL**)** and CSS. Currently the two services are separate and paid differently. The perception is that CSS is more treatment plan driven and SCL is more about basic needs. Both are about making sure that the individual is provided supports that enable them to function in the home and community. CSS sounds like more of a core service than SCL.
- There may need to be a combination or blending of CSS, SCL and case management services if they appear duplicative.
- Use of peer and family supports in service provisions-peer delivered services**.** Family PsychoEducation is an EBP, it belongs under recovery supports.
- Intensive psychiatric rehabilitation services.

RECOVERY SERVICES

The group identified recovery services that should be included in core services.

- Peer support
    - Peers can work in many parts of the system. Peers are an untapped resource and should be considered part of a workforce development strategy. Also peer self-help centers. Research supports self-help centers that also focus on wellness activities. Also, peer navigators and peer wellness navigators.
- Recovery support coaching
- Supported employment
- Supported education for adults
- Alternative therapies such as meditation
- Transition services for youth to adult, for people leaving institutions
    - Comment from Kevin: Should that be captured in services already identified? Response was yes it should but currently doesn't happen consistently.
- Support groups-led by trained peers
- Emphasis on consumer choice although this more about a principle than a service
- Where does Supported Community Living belong?
    - Kevin views it as a part of supported housing services.
- Is transportation a separate domain?

<u>Kevin's Comments Regarding Prevention</u>

- The mental health field is new at this, substance abuse has been doing this longer.

- Mental illness prevention will fall toward children's system as research regarding early onset of serious mental illness points toward this.
- Substance Abuse prevention should be considered as prevention of substance abuse and will also help prevent mental illness.

Workgroup Comments

- There is very little Mental Health prevention going on. However, there is early intervention with Mental Health First Aid (MHFA) and Psychological First Aid.
- Some agencies are providing bullying programs, teen screen, and gambling prevention.
- There is screening and brief intervention, but also a need for relapse prevention.
- Comment from Kathy Stone: The Substance Abuse block grant prescribes prevention activities but they have been reevaluating to look at more general health education and wellness, suicide issues, bullying, in other word, need more holistic approach to prevention on early recognition and reducing stigma.
- Discussion of Mental Health First Aid and Psychological First Aid as education and prevention/early intervention activities.
- Kevin discussed that these types of trainings can provide information to help avert future tragedies like the Tucson shootings. Arizona and some other states implemented MHFA trainings following that incident.
- Wellness services can be part of recovery as well as prevention. Peer support can be relapse prevention as well as ongoing support.
- We can create more awareness to target services to those at risk.
- Wellness in recovery is important. More individuals need health coaching in the system due to shortened life expectancy for those with serious mental illness.
- School based services are a placeholder for the children's workgroup but it can be a prevention activity as well. For the adult group, this may apply to individuals in post-secondary settings.
- Does DHS have a role in veterans' services? Chuck says not really, we don't have expertise.
- Many vets don't go to the VA, so they do touch the public system.
- Whose responsibility is it to cover them? This is something to be considered.
- There should be better coordination between systems.
- There are funding issues as well as lack of expertise in dealing with those who have returned from active duty.
- Veterans' issues also cross over to the brain injury workgroup.
- Some states are creating special processes to deal with veterans' issues.

Topic Of Mental Health And Primary Care Coordination

What type of system should be in place to ensure this happens? Workgroup comments on services needed and importance of coordination.

- General health screening needed, also follow up for those who receive meds but don't have ability to follow up.
- There is no standardized health screening in the current system.
- There should be care coordination with the primary health care provider.

- Many primary care providers don't have a place to refer to when they do identify a mental health issue or medication alone doesn't work.
- Other states have a psychiatric consultation line for primary care physicians to consult with a psychiatrist on these issues. It helps ensure continuity of care as the individual continues to receive services in the medical home.
- Medical care available on site where mental health and substance abuse services are provided. The individual receiving treatment is connected to a behavioral health provider, so location of the health care provider in that setting supports that.
- Integrated health homes/Bidirectional integration of health care and mental health –the health home can be the primary care provider or the behavioral health provider can.
- There are licensure issues related to co-location but it is possible. Each player will continue to have a role-sometimes primary care may take the lead, sometimes mental health.
- Medication therapy management -some agencies do it independently, some pharmacists could but don't get paid for it. We know that people may be taking the wrong medication or be prescribed too much from different docs.
- An individual receiving services since 1978 never had a team that would coordinate unless she insisted. Psychiatrists and therapists weren't in the same location or didn't talk if they were.

Comments From The Group Regarding How To Measure Or Identify Effective Collaboration

- Some monitoring will be within quality assurance.
- Mandate it.
- An electronic health record helps coordinate services when available.
- Unless you have some mandate for coordination it probably won't happen. It has to be a priority.
- Barriers to collaboration – coordination, time management and reimbursement issues.

Kevin's comment: If we suppose care coordination leads to better outcomes, then monitoring of outcomes should help identify those that do it.

Further Workgroup Comments On Health Homes

- The system should be paying attention to duplication and encourage collaboration by not paying for things twice. The billable hour drives what happens.
- Magellan looks for proper follow up on identified mental health issues for those in substance abuse treatment.
- Health homes help define who is responsible for coordination when multiple providers are providing services.
- Accountable care organizations will help define that also.
- Medicaid has guidance on health homes and writing State Plan Amendments.

Comment from Kevin: What are issues that providers may have about joining health homes? Other states have struggled with what entity should be the health home-the provider, the insurance plan, etc. In New York, for example, it could be the targeted case management entity. If health homes are going to be a core service, it will have to be defined. Who pays for the mental health clinician to be at the primary care site?

Workgroup Comments

- CMHCs are reimbursed to do certain safety net things. Could add health services to the safety net. Just because they aren't there now, doesn't mean they can't be added.
- Some health clinics do employ a therapist directly, or co-locate a therapist there but the therapist stays under the employ of the CMHC.
- There is a facility in Cedar Rapids that provides housing with a social worker and services on site. It is focused on homelessness but would address mental health services as well.
- In a city in NJ, using a data analysis, individuals over utilizing the ER were traced back to a few apartment complexes. Mainly an indigent population lived there. Services were then targeted to the complex on site in order to provide better access and to reduce costly ER visits.

Final Comments From The Group

- Health homes should be a stand-alone domain. If something is not assigned then it may be lost.
- Magellan and Iowa Care are already developing health homes models; this should fit into those proposals.
- Question regarding what psychosocial rehab, there should be more options beyond day treatment, partial hospitalization, and psychosocial rehabilitation as defined in the Chapter 230A revisions in SF525. ACT and other modalities should be added.
- Psychosocial rehab was meant to be a broad description of those types of services, not one single service.
- Questions around what day treatment means in terms of Medicare conditions for community mental health centers and how this affects core services.

Final Comments/Thoughts From Kevin

- If the group is to start recommending some services, are there some they are willing to not recommend? This could include services that are not supporting desired outcomes. It may be that EBP programs that are not operating to fidelity are not funded. There may be a need to re-bid underperforming contracts.
- Consider people who have been getting the same service for a long time without being reviewed for change or improvement.
- Also must consider supported employment issues. If we want to promote identified outcomes, need to focus on supported employment issues.
- Can a person voluntarily admitted to state hospital be served in the community at less cost? Possibly, but it depends on the reasons for referral to the hospital.

Final Comments From Chuck:

- The service array is fine. It is the quality of the authorization process and how to determine the right amount, scope and duration of services. Our system is currently inconsistent in this.
- Also, how do we determine the right package in the waiver system?
- Children's MH workgroup is looking at out of state; 60-80% could be served in state. There is a lack of providers and services.
- How do we measure the outcomes, and how do we change the payment and authorizations based on the outcomes, or do we get continue doing the same thing indefinitely?
- Some of this may be beyond the regional level.

NEXT STEPS

The group will start to work on the more difficult recommendations. Legislators want concrete recommendations to work from.

PUBLIC COMMENT:

COMMENT:	There needs to be a central information point - centralized intake and database, with information shared at all levels. This system should collect data so that the system knows which programs work. This has worked for HMO's who looked at programs outcomes to decide which programs to fund or not. The system will need all providers reporting data.
COMMENT:	Thanked the group for the work being done. Discussed the Integrated Health Home Project, which is working well so far, and discussed the importance of public private partnerships along with the need to make sure acute care actually works. There is a concern that people are being discharged from hospitals with a 2-day supply of meds and then relapse before they can be seen at the CMHC. The cost of medications for non-Medicaid individuals is also a concern. The Sioux City hospital psychiatric unit is taking people across Iowa. How can services be integrated when people are served far away from home? Also discussed that residential care for individuals with mental illness is not equivalent to that provided for individuals with intellectual disability. Magellan should start paying for residential services. Currently individuals have to go through Habilitation, which is a difficult process. There are also cultural competency issues-how does redesign apply to all cultures in Iowa?

COMMENT:	Dental care and tobacco cessation issues should also be considered as many individuals with mental illness struggle with these issues. Peer support funding issues for about half of clients are reimbursable, because counties won't pay for it right now. Concerned that using the diagnosis of a severe mental illness as part of eligibility criteria might leave out persons in crisis or not immediately diagnosable. Also there is a need to focus on prevention issues as well.
COMMENT:	Veterans' families will have needs as well as the veterans. There should be more collaboration among the service providers.
COMMENT:	Discussed prevention services and the three levels of prevention from the public health model: primary, secondary and tertiary. Anything primary has to be focused on young children. Trauma informed care should be part of the prevention service. Also expressed a concern about the providers who provide some but not all of the services of a CMHC. There has to be a way to identify agencies that do well in certain areas, have certain skills, and can work together, as not one agency does all the services in their geographic area.
DHS RESPONSE:	DHS doesn't look for one provider to do everything and wants to keep supporting choice.
COMMENT:	Discussed the concern regarding people with mental illness having a significantly shorter life expectancy. Peer Support Whole Health addresses that as well as WRAP.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.